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Cost, Quality and Access-to-Care Issues in the U.S. / Ohio / Northeast Ohio

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INTRODUCTION

This issue of the Quarterly Health Care Report provides the reader with a wide spectrum of articles under the heading of cost, quality and access to care. In addition, this issue will specifically focus on President Bush's healthcare proposal along with universal health insurance initiatives at the state level. Finally, we will discuss the issue of hospital-based infections, and the importance of not being satisfied with less than perfect results.

COSTS

Four Reports Predict Wide Range of Health Benefit Cost Increases for 2007

The good news: Health plan costs are expected to grow at a slightly slower rate in 2007 but still outpace inflation. The bad news: Just what those hikes will be varies widely depending on who makes the predictions. Four different firms predict increases in 2007 ranging from 5.6% to 11.6%.

On the low side, Mercer Health & Benefits recently announced that health care costs will increase 5.6% on average in 2007, and Towers Perrin places the average health care cost hike for next year at 6%. In contrast, the Segal Group predicts an 11.6% increase in PPO costs and an 11.1% rise for HMO coverage. Meanwhile, more in the middle, Milliman predicts HMO rate increases at 9.7% and PPO hikes at 10.7%.

Here then, is a look at the various healthcare cost projections and reasons for the spread:

Mercer's forecast. Preliminary employer survey findings from Mercer Health & Benefits found that if employers made no changes to their benefit plans, their average health premium cost increase would be about 9% - more than double the inflation rate. Few employers can absorb an increase of that size and therefore they are taking steps – such as changing plans, increasing employee cost sharing, and other plan design alterations – to decrease cost hikes. When this is done, employers project an average increase of 5.6%, down slightly from 2006's projected 6.1% increase overall.

Towers Perrin's predictions. Tower Perrin, similarly to Mercer, surveys employers and takes into consideration changing plans, increasing employee cost sharing and other plan design changes. Towers Perrin's database includes data from 170 of the nation's largest employers.

Milliman's outlook. Milliman's survey was sent to the nation's HMOs and fully insured PPOs that serve large and midsize employers. About 40% of eligible insurers participate.

Segal's projections. Segal's, similarly to Milliman's, surveys reflects projections of insurers and managed care organizations.

Additional reasons for the spread in predictions. Insurers have a vested interest to project gloomier outlook for rising costs, since these trends are used to encourage small and midsize firms, those that are less likely to self-insure, to accept their forecasted cost increases. **Reason:** Companies that buy health care insurance typically yield six times the profit (Source: WSJ) of larger companies that self-insure coverage and they use insurers only to administer benefits. ([IOMA](#). "4 Reports Predict Wide Range of Health Benefit Cost Increases for 2007," Managing Benefit Plans, Issue 06-12, December 2006)

Tom's Comments:

Ideally, if an employer can tolerate the risk, it is more beneficial for them to be self-insured than fully-insured. As one would expect, there is a cost (in fact a hefty cost as noted above), in having a fully-insured policy. Self-insured employers will purchase stop-loss insurance (aggregate or specific) to protect them from unusually high healthcare costs or claims, but even with this purchase they are usually ahead of those organizations that are fully-insured. Approximately 80% of employers with 1,000 or more employees are self-insured and that number is increasing. Conversely, smaller employers (less than 100 employees) are fully insured, which also affects their ability to purchase affordable insurance to cover their employees (See additional articles concerning small employers throughout this issue of QHCR).

The New Role for Managed Care Organizations

Insurers are best positioned to provide consumers with the information they need to effectively shop for healthcare services, but will they deliver?

MCOs' ability to deliver will depend upon a number of factors, including: the benefit designs that give patients incentives to shop based on price, their ability to provide patients meaningful price information, and the development of quality measuring tools to inform patients who choose lower-cost providers or services about whether they are sacrificing quality, and by how much.

In practice, the complexities of communicating meaningful price information to consumers and their ability to use this information will limit how effective shopping for medical care can be and how much this approach can affect care delivery.

In a market economy, consumer price comparison plays an important role, spurring greater efficiency and value (consumers' judgments of combinations of quality and price). Price shopping not only enables consumers to benefit from choosing providers that offer better value than others but, potentially of greater significance, also forces market-level gains by pressuring providers to lower their costs or increase their quality.

Although price data are often not accessible to consumers, their usefulness, when they are made available, depends a great deal on the form they are presented in. Although the traditional function of insurers has been to pool risks, the managed care revolution created a new role for insurers: an intermediary engaged to act as an agent for enrollees shopping for medical services.

Many see opportunities for health plans to meld consumerism with managed care tools, such as provider networks. One thrust is to provide financial incentives for consumers to favor providers with lower per episode costs and higher measured quality. For example, in a "high performance network," the health plan analyzes cost and quality data by physician specialty and designates some of the physicians' practices as "high performance," offering lower cost sharing for patients, who use those practices.

Information on prices negotiated with hospitals and other facilities is probably a higher priority than information on prices of network physicians because the former vary more within a market.

One example of a user-friendly approach to providing information to consumers concerning negotiating healthcare costs was used by Blue Cross of California. Blue Cross of California posted for its PPO enrollees ratings of the costliness of hospitals. It followed the approach of Zagat guides to restaurants, where "\$" is assigned to the lowest cost hospitals and "\$\$\$\$" to the highest. This approach engages the plan's formidable actuarial resources to transform complex data into something more meaningful to consumers. But the plan discontinued this feature in 2004, citing little use by enrollees and pressure for price increases from hospitals identified as low cost.

Gathering and understanding price information for medical services is more difficult than for many other services because of the complexity of medical care and the urgency with which decisions must be made. The MCO price and quality tool could be more powerful when used to identify a provider or delivery of a system to use on a regular basis than for "a la carte" shopping for individuals services. ("[Shopping for Price in Medical Care](#)," Paul B. Ginsberg, Health Affairs 26, no. 2 (February 6, 2007; 10.1377/hlthaff.26.2.w208)

Tom's Comments:

Managed Care Organizations (MCOs) are attempting to evolve from their historical "traffic cop" role into more of a facilitator. MCOs have the

data, resources and the expertise to play this facilitator role. One of the main goals of consumer health care initiatives is to convert the consumer to a prudent purchaser of healthcare services. One of the keys to this transition would be to provide the consumer user-friendly cost and quality information that they can use when purchasing healthcare services. The practical obstacles of this goal, at the very least, will be very challenging.

The average consumer lacks both the expertise and the time to thoroughly investigate the differences in cost and quality, especially during times of stress which is often the case concerning healthcare purchases. Efforts to make this information user-friendly enough to meet the needs of the average consumer could be insurmountable.

As stated in the above article, MCOs have the data, resources and expertise to do much of the work relating to the search for value. MCOs could then, through the use of benefit designs or relatively simplistic but valuable classifications guide and, in some cases, steer consumers to value oriented providers.

Competition between the MCOs that would take on this task would also create both incentives and measures that would challenge these organizations to provide better value in their facilitator role.

Linking this facilitator role with products that engage the consumer with a financial stake in the transaction (deductible, co-pays, etc.) would be an ideal combination.

Also see subsequent article in this issue of BW QHCR, involving Value-Based Benefit Designs, to identify another way that MCOs can play this facilitator role.

President Bush's Healthcare Proposal

President Bush has proposed some major changes in the tax code to be effective in 2009, to partially address some of the cost and access to care issues that plague our healthcare system. The administration proposes to grant everyone who gets qualifying health insurance a standard deduction -- \$15,000 for family coverage or \$7,500 for single coverage -- of their income subject to taxation. Those with family policies exceeding \$15,000 in value would have to pay taxes on the excess amount.

The administration also has a proposal that would allow the states to redirect an estimated \$30 billion in federal money that now helps to finance hospitals that provide charity care and use it instead to subsidize health insurance for the poor.

Based on this proposal, families that spend less than \$15,000 on their health coverage (either on their own or with an employer's contribution) would come out ahead. For example, a family that spends \$13,000 per year on health insurance could claim the full deduction (\$15,000). The administration says about 100 million people with employer-sponsored coverage would see their tax bills go down.

Other winners would include the 17 million people who buy insurance on the individual markets, who would for the first time enjoy a tax break on the money they use to pay health premiums.

On the losing side are consumers with more expensive policies, especially those financed by employers, who would have to pay taxes on the money used to pay premiums exceeding \$15,000. About 30 million people with employer coverage would see their tax bills go up in the first year, the administration says.

Advocates say the proposals would hold down health-care costs by motivating people to seek plans that cost \$15,000 or less, and would help put basic insurance within reach of about 5 million of the uninsured. (**Note:** the White House estimates that as a result of this initiative, approximately 3 million people who are currently not covered will acquire insurance coverage). Still more people would gain coverage, per the **advocates**, with the help of another Bush proposal to redirect some federal health money to new grants to assist states in funding innovative ways to cover the uninsured.

Critics of the proposals note that the \$15,000 deduction would increase annually with inflation, which is less than the rate of health insurance premiums. The result of this inflation gap would be that the initial projection of 20% of people having benefits greater than the cap would increase to 40% in ten years. The administration's own figures show the government losing as much as \$40 billion in tax revenue in the first year, but breaking even over a decade as more revenue rolls in.

Critics also state that wealthier families who benefit from the deduction would get a much greater value than less affluent families. The \$15,000 deduction would be worth \$5,250 to a family taxed at 35% but only \$1,500 to one taxed in the 10% bracket (tax credits may be more equitable, but

other issues would arise). Moreover, more than half of the uninsured are too poor to owe any taxes and would see no benefit, according to an analysis by the conservative Tax Foundation. (["Experts Examine Bush Health Plan," Christopher Lee and Lori Montgomery, Washington Post, January 25, 2007](#))

Critics are also concerned that this proposal could destabilize the employer-based insurance market that currently covers 147 million Americans. Specifically, if the tax code is changed to allow you to take that deduction as an individual, then employers could elect to no longer provide health insurance for their employees and allow their employees to purchase it on the open market. (["President Bush Promotes New Health Care Plan," Susan Dentzer, NewsHour, January 30, 2007](#))

Tom's Comments:

I think it is important to evaluate and discuss any proposals dealing with health care reform. We are prone to either solidly supporting or criticizing a proposal depending upon our political leanings or own self-interest from a stakeholder's perspective.

In evaluating the Administration proposal, I would like to initially focus on their cap number as it relates to deductibility of healthcare benefits. The Administration is proposing a \$7,500 cap for single coverage and a \$15,000 cap for family policies. One could debate the appropriateness of the actual dollar amount of the cap and the fact that it would increase annually with the rate of general inflation rather than healthcare inflation, but the concept of a cap does make sense.

Currently, the government provides hundreds of billions of dollars of tax subsidies to Americans who have their insurance through their employer. The concept of putting a cap on this subsidy does make sense, especially if you could use these subsidies to expand coverage for more of the uninsured.

Also, as noted in the discussions relating to consumer driven health care, health insurance does insulate the consumers from the true costs of their decisions. I think it would be reasonable to develop health plans that provide the consumer with a financial stake in the healthcare transaction. I would caution, as we discussed under the Value Based Benefit Designs article, that any co-pays, etc. should not discourage under-utilization of needed services.

The expansion of the above health care deductions to all Americans (not only those receiving health insurance through their employer) who purchase qualifying health insurance also has merit. The actual impact of this expansion will have a minimal effect on the number of the uninsured (per the Administration's estimate 3 million), but at least it is going in the right direction.

There also has been much criticism of the Administration's proposal concerning its potential negative impact of destabilizing the employer-based insurance market that currently covers 147 million Americans. Specifically, if the tax code is changed to allow one to take the deduction as an individual, then employers could elect to no longer provide health insurance for their employees and allow their employees to purchase insurance on the open market.

This destabilization concern should not be taken lightly. It wasn't too long ago that most employers offered defined benefit pensions for their employees. 401-K plans with generous employer matching also became part of the retirement package. After a period of time, employers began to switch from defined-benefit pension plans to defined-payment pension plans in order to limit their financial exposure. Employers also started to reduce their 401-K contribution as part of their austerity programs. Now many employers have eliminated their pension plans (both defined-benefit and defined-payment), and employees are depending upon their 401-K plan as their retirement, supplemented by Social Security payments.

The above scenario could potentially also apply to employer-based insurance. Especially vulnerable would be employees that work for small to mid-size companies that currently offer health insurance. This concern is magnified when one evaluates the individual insurance market which is individually underwritten (health risk issues) and high cost.

The Administration also has a proposal that would allow the states to redirect an estimated \$30 billion in federal money that now helps to finance hospitals that provide charity care, and use it instead to subsidize the health insurance for the poor. Again, this proposal has some merit if, in fact, the dollars are able to be used to further expand coverage for the uninsured.

I believe that states need to thoroughly evaluate this issue prior to making any decisions concerning funding flow. Currently, hospitals that serve a disproportionate percentage of the uninsured provide an important safety-net for our communities. There should not be any rash decisions concerning the redirection of these dollars for other programs, until the

approach is thoroughly evaluated from a number of perspectives, including the financial well-being of these safety-net providers.

While each of the Administration's proposals have some merit, as noted above, the fundamental flaw with these initiatives is the fact that they are not part of a comprehensive plan to address health care cost, quality and access issues in the U.S.

The best analogy would be that of a jigsaw puzzle. The aforementioned proposals in isolation may represent a positive piece in the puzzle, but since we have no idea of the end picture we cannot be sure. In fact, if fears of the destabilization of the employer-based insurance market are in fact true, the universal applicability of health benefit deductions piece of the puzzle could be counter-product in addressing health care issues of cost, quality and access.

There is no "silver bullet" when it comes to addressing healthcare issues, and all countries to varying degrees, are struggling with issues of cost, access and quality. There also is not one "right way" to address these issues from a systemic basis, but we need to start identifying our societal goals in regards to cost, access and quality, and then determine how to find, as well as fit, the puzzle pieces to achieve that overall objective.

The discussions and initiatives that are occurring on the state level (See "Universal Health Insurance and the States" article that follows in this issue) will play an important role in this debate. Hopefully these initiatives will allow us to further pilot various approaches to cost, access and quality issues at the state level.

QUALITY

Value-Based Insurance Design

When everyone is required to pay the same out-of-pocket amount for health care services there is enormous potential for both under- and overuse. In health care financing there is a trade-off between cost containment initiatives and access to medical care services. Efficiency should promote the use of "valuable" interventions whose expected net clinical benefits justify the associated expenditures and limit access to those services whose costs exceed expected.

Ideally, uniform patient co-payments would discourage use of low-value care only. This assumes, however, that patients can distinguish between high- and low-value therapies and respond to co-payments accordingly. Yet a large body of evidence demonstrates that higher co-payments reduce the use of both highly valuable and marginally valuable health care services and may result in worse health outcomes.

In response to likely adverse clinical effects of the current trend toward higher co-payments, the Value-Based Insurance Design (VBID) approach, advocates the co-payment rates be set based on the value of the clinical services (benefits and costs) – not exclusively the costs.

Because consumers' behavior might not follow standard assumptions, targeted reductions in the level of cost sharing can increase value by reducing under-use (for example, **reducing cost sharing for beta-blockers therapy for patients with congestive health failure** can increase beta-blocker adherence and therefore value in the health care system).

In practice there are **two** general approaches to VBID targeting. The **first approach** simply targets clinically valuable services for co-payments (for example, beta blockers). The **second approach** targets patients with select clinical diagnoses (for example, Congestive Heart Failure), and lower co-payments for specific high-value services (for example, beta blockers and angiotension converting enzyme (ACE) inhibitors).

The second approach, although requiring more sophisticated data systems to implement, creates a differential co-payment based on patients' characteristics. Programs using this approach typically identify patients with specific diseases, such as diabetes or coronary heart disease (CHD), and reduce co-payments for only the high-value services for these payments.

Two examples of the second approach are the municipality of Asheville, North Carolina, and the University of Michigan. Both of these employers implemented a program that lowered co-payments for selected medications for employees with diabetes. The Asheville program is pharmacist led and includes coached self-management. Both programs have also been financially successful for the employer. (["Value-Based Insurance Design," Michael Chernew, Allison Rosen, and Mark Fendrick, Health Affairs 26, no 2 \(2007\): \(published online January 30, 2007; 10.1377/hlthaff.26.2w195\)](#))

Tom's Comments:

This is another example of a potential facilitator role for Managed Care Organizations (MCOs). As discussed under Tom's Comments, relating to the "Shopping for Price in Medical Care" article, MCOs can play a valuable role in guiding consumers to quality cost-effective care. Value-based benefit designs potentially cannot only address an obstacle to effective care (egg. Co-pays tied to disease management programs), but can also provide incentives for quality care, especially when linked with the appropriate overall benefit design and the appropriate providers of care.

Mandatory Reporting of Infection Rates at Hospitals

Per researchers from the University of Pennsylvania, data shows that infections acquired in a hospital setting are largely the result of the processes of care followed by a hospital in treating patients, rather than the medical condition of the patients themselves when they are admitted.

The study released on November 27, 2006, published in the "American Journal of Medical Quality," **"will do much to help explode the myth that infections ... cannot be prevented,"** said Dr. David Nash, Chairman of the Department of Health Policy at Philadelphia's Thomas Jefferson University and the editor of the medical journal.

The Pennsylvania data released on November 14, 2006 on the numbers of infections at individual hospitals in the state also showed large outlays for treatments. A total of 19,154 cases of hospital-acquired infection occurred in the state in 2005, according to the data. Hospital charges for treating the patients totaled \$3.5 billion. The death rate for patients with a hospital-acquired infection was 12.9%, compared with 2.3% for patients without infections.

Dr. David Nash and Michael Volavka (Executive Director of the Pennsylvania Health Care Cost Containment Council), said that requiring hospitals around the country to publicly post their infection rates would spur their executives to quickly take steps to improve care. Volavka further said if Congress were to deny Medicare payments for cases of hospital acquired infection, hospital executives would start scrambling today to figure out how to eliminate them.

Currently the American Hospital Association is working with Medicare on disclosing data on hospital compliance to three measures relating to preventing surgical infections. Volavka said reliance on those “process” measures by hospitals and the Medicare program is “disappointing.” There are many elements that contribute to whether or not a patient develops a surgical infection, and those processes are just one of the many steps along the way to preventing infections, Volavka said. “Outcome” measures should be used instead of process measures, he said. ([“New Data May Strengthen Push for Mandatory Reporting of Infection Rates at Hospitals,” John Reichard, CQ HealthBeat, The Commonwealth Fund, November 27, 2006](#))

Per an article written by Dr. Donald Berwick, CEO of the Institute for Healthcare Improvement & Clinical Professor of Pediatrics at Children’s Hospital and Harvard Medical School and Dr. Lucian Leape, Adjunct Professor of Health Policy at the Harvard School of Public Health, that **according to the Centers for Disease Control and Prevention, 2 million Americans get hospital infections each year. Per Berwick and Leape, they do not need to get those infections. Rates in Norway and Sweden are nearly zero.** ([“Perfect is Possible,” Donald Berwick M.D. and Lucian Leape, M.D., Newsweek, October 16, 2006](#))

Tom’s Comments:

I do not have a clinical background, but as a consumer (along with my family) of healthcare services; I, along with all of you, have a vested interest in the overall theme of this article. If indeed, it is possible to eliminate or prevent most infections in the hospital setting, it should be not only a goal, but a mandate. The experts cited above present convincing arguments for the required reporting of hospital based infections, especially as it relates to spurring the industry into more effective preventative measures.

Finally, while it is important for hospitals to report their status in complying with measures that prevent surgical infections; this initiative should not preclude the ultimate goal of the elimination of hospital-based infections.

Fast Facts:

- Asthma afflicts around 20 million Americans, and direct and indirect costs relating to the disease are estimated to be \$18 billion on an

annual basis. Allergic asthma is the most common form of asthma. Allergic asthma is also a family disease, adversely affecting the dependability of employees whose children suffer from the condition. When properly treated, asthma sufferers have fewer emergency care visits, fewer hospitalizations, and reduced lengths of hospital stays. Children miss fewer days of school, so parents miss less work. (["Asthma in the Workplace," Managed Care Magazine, Volume 1, No. 1/ Fall 2006](#))

ACCESS TO CARE

Fast Facts:

- The Census Bureau reported that the number of non-elderly uninsured Americans had increased in 2005 by another 1.3 million people, for a total of 46.1 million uninsured. Of the 1.3 million increase in the number of uninsured, 1.0 million were adults and 300,000 were children. (["Why did the number of uninsured continue to increase in 2005?" , John Holohan & Allison Cook, Kaiser Commission on Medicaid and the Uninsured, October 2006](#))
- The uninsured rate among the near poor (those with income between 100% and 199% of the Federal Poverty Level) increased from 28.0% to 29.8%, and that accounted for 1.0 of the 1.3 million increase in the number of uninsured. (["Why did the number of uninsured continue to increase in 2005?" , John Holohan & Allison Cook, Kaiser Commission on Medicaid and the Uninsured, October 2006](#))
- Between 2001 and 2005 the number of the uninsured employees grew by 3.4 million. Two-thirds (67%) of the growth was among low-income employees, with family incomes less than 200% of the poverty level and almost half of the growth (46%) occurred among those working in firms with fewer than 25 employees. Nearly 60% of the growth of the uninsured was among full-time employees, and a large majority (58%) was also employees under age 35. (["Changes in Employees' Health Insurance Coverage, 2001-2005," Lisa Clemans-Cope, Bowen Garrett, Catherine Hoffman, Kaiser Commission on Medicaid and the Uninsured, October 2006](#))

Tom's Comments:

Two key points can be taken away from the above data. Any health care reform proposal that can increase coverage to a minimum of 200% of the poverty level would have a very positive impact on the number of people that are uninsured. Also any strategy that addresses smaller employers (egg. fewer than 50 employees) and their ability to purchase affordable insurance would also have positive impact on the number of the uninsured.

State Healthcare Initiatives

Universal Health Insurance and the States

Driven by state proposals for universal health insurance coverage and rising health care costs, comprehensive health reform is back in the news. At least 20 states have taken significant steps toward covering the uninsured or are seriously considering proposals to do so. California's governor Arnold Schwarzenegger put forward a major plan recently. Massachusetts continues to implement its universal coverage plan passed by the legislature this past April (See July 2006, BW QHCR for an article on Massachusetts plan). In Congress, Edward Kennedy, has called for covering all Americans, while Senator Ron Wyden of Oregon introduced a major universal coverage plan in December of 2006.

Recently The Century Forum sponsored an exchange between leading experts on the impact of these state initiatives and the prospects of universal coverage. The following is a summary of some of the questions and responses relating to the state initiatives. If you are interested in their detailed discussion and the panelists' backgrounds, go to <http://www.tcf.org/list.asp?type=PB&pubid=601>

How do the state initiatives influence the national debate over universal coverage?

"States can serve as laboratories for specific policy issues. Ultimately, however, the states will not be able to deal with this problem on their own; they will need not just federal financial support, but also changes in the laws, like the Employer Retirement Security Act of 1974, that excludes self-

insured companies (egg., 80% of employers with greater than 1,000 employees are self-insured) from state mandates, regulations, etc.”

“Many of the state initiatives are built on individual mandates (similar to the requirements relating to car insurance), which could be popular on a national basis.”

“California is the key. More than 12% of all Americans live in California. California has a much bigger uninsured problem than the other states (egg. Massachusetts). To paraphrase the old song, “If you can make it in California, you can make it anywhere.”

“In the near term, the most promising avenue for reform would be for the federal government to encourage states to undertake programs to extend coverage, promote quality and control spending. President Bush’s healthcare proposal relating to the use by states of federal dollars to increase access for the uninsured is an example of such an initiative.”

“Comprehensive health reform is back on the political agenda for the first time since 1994 –that is the political significance of the ambitious plans being pursued by the states. States must cope with the pressures of the uninsured and costs which are felt particularly strongly in their Medicaid programs, so it is not surprising to see some of them embracing comprehensive reform.”

“California is important from a number of perspectives including having a Republican governor of a very large state that is not on the east coast; assert that everyone should have health coverage. Employing the notion of “shared social responsibility” rather than “social insurance” provides vocabulary for rational political discussions about national health reform that had become impossible in recent years.”

What are the single biggest positives as well as negatives in the state plans (specifically California and Massachusetts)?

“Both California and Massachusetts have adopted the “pay-or-play” system (businesses must provide health insurance or pay a tax to the state) and an individual mandate to buy insurance (similar to car insurance mandate), with subsidies for low-income persons and regulation of the insurance market. This suggests that combining individual responsibility to purchase insurance with employer responsibility to finance insurance is an appealing political formula that may attract bipartisan support.”

“The biggest problem for California will be the price of covering their large number of uninsured and undocumented aliens.”

“The best provision of the California plan related to comprehensive insurance reform, including guaranteed issue and stricter regulation of insurance loss ratios (impacts insurance companies’ profitability). The California proposal also calls for limits on what insurers can charge based on age or health status. Massachusetts (and only a couple of other states) already has mandated community rating in the individual insurance market.”

“Probably the best thing about the California plan is its realistic financing, which draws on hospitals, doctors’ employers and the federal government alike. This may also prove to be its political downfall. By contrast Massachusetts’ plan is vulnerable to uncertain financing down the line, perhaps as early as 2009.”

“Another drawback is that the state plans may run afoul of ERISA, the federal law that excludes self-insured employers from state mandates and state premium taxes.”

Should employer-based coverage be tuned up or traded-in?

“The employer-based system still covers more than 150 million Americans. The system may contract somewhat, but until the nation develops a better mechanism for pooling risks than the workplace, with all of its admittedly serious flaws, employment-based coverage will remain indispensable. If the California’s “pay-or-play” system is implemented, most employers would find it less costly and less bothersome to drop coverage and simply pay the alternative payroll tax the plan requires.”

“To paraphrase Churchill, employer-based insurance is the worst option for providing health insurance except for all of the others.”

“The employer-sponsored market is still the core of health coverage in the United States. It is also not incompatible with universal coverage. Employers play major roles in a number of national health systems, such as in Germany. Building on the existing infrastructure of employer-sponsored coverage could make sense, if the issues of portability, security, and equity are worked out, and might fit better with American values and perceptions than other, more centralized approaches.”

“It would be better to create a new low-cost alternative for employers, allowing them to buy into a new public insurance program modeled after Medicare by paying a modest share of payroll. If employers were required to either purchase coverage through this new public insurance pool or provide comparable coverage privately, All Americans with direct or family ties to the workforce (roughly 94% of those younger than 65) would immediately be insured.”

Most of the state initiatives rely heavily on private insurers to organize the delivery of care. Why should, or shouldn't private insurers be kept in the mix?

“No amount of moral outrage or substantive virtue will ever enact single payer. Keeping private insurance alongside public insurance in a mixed system is the only political viable option; the key is the willingness to regulate private insurance to make it fairer and perhaps less wasteful.”

“In my ideal world, a national health service would cover basic services and private insurance --subsidized for those who need it ---would cover above the limit. Like in France, a high floor and no ceiling is the way to go. That said, it's hard to imagine any Congress or state dissolving the multibillion dollar insurance industry with a single vote, so the question may be how best to regulate the insurance industry.”

In theory, private plans ought to have more flexibility to introduce new benefits, coordinate care, measure results, keep down costs, and promote information technology. The managed care “revolution” of the 1990s produced some examples. Kaiser Permanente, the giant California-based HMO, is light years ahead in introducing practical uses of information technology and care coordination. In other countries, the existence of private insurance is a valuable safety valve for people who want to “buy up” from government's universal coverage plan. But most efforts by private insurers seem long on public relations and short on reality. The Veteran's Administration and, increasingly, Medicare have been taking the lead on quality and care coordination.”

Apart from failing to insure some 46 million Americans, the U.S. health care system faces enormous challenges. These include the questionable value of U.S. health spending measured by the relative health of Americans and our lagging use of information technology. To what extent can, should, or must universal coverage proposals involve fixing what ails the medical system (or medical non-system) as a whole?

“Covering the uninsured would help do away with some of the most egregious systemic flaws, such as the unnecessary use of emergency rooms and roundabout ways of paying (or not paying) providers who treat the uninsured. Since the uninsured are less likely to see a doctor regularly, or to treat their illnesses promptly, universal coverage would be helpful for promoting population-based strategies for improving health care. But failing to make progress toward a health system that contains costs and promotes value better could hamper the cause of universal healthcare. The new costs of covering the uninsured will materialize before any real savings materialize. If you graft more coverage into the existing system, you are going to get, largely, the same old system with a higher price tag.”

“Universal insurance is a necessary precondition for addressing these problems, but should not be held hostage to broader debates about the quality of American medical care or about what Americans need to do to improve their own health. ”

“The key to changing the organization of the delivery of health care is not universal coverage. It is rather improved management that emphasizes medical teamwork and uses information technology extensively and creatively. To achieve this result, it would help greatly to realign the payment system to reward interventions that are known to be effective.”

“Some have argued, seriously, that it is irresponsible to pursue universal coverage when the system providing the care is inefficient –if we fix the system first, the savings can pay for coverage for more people. This logic seems backwards. A far stronger argument can be made for the case that at least some of the inefficiencies (emergency room usage, lack of proactive disease management and preventive medicine) that plague healthcare in America are the result of lack of coverage, or inadequate coverage.” <http://www.tcf.org/list.asp?type=PB&pubid=601>

Tom's Comments:

As discussed under comments relating to the Administration's proposal, the discussions and initiatives that are occurring at the state level provides us with an opportunity to pilot some innovative ways to address healthcare issues of cost, quality and access.

One of the key positives of these state initiatives is the fact that to be successful in addressing issues of cost, access and quality the state's need to develop a sustainable strategy both on the short and long-term. States

are experiencing major budgetary challenges as competing priorities battle for funding (Egg. K through 12, Higher Education, Medicaid, etc.). The growth of Medicaid, especially, represents serious challenges to the states. While long-term care is the major portion of the Medicaid budget, states will still need to find ways to better use their dollars in addressing the health care under-served.

States are also seeing first hand the impact of the increasing ranks of the uninsured within their boundaries, as more employers elect to no longer provide insurance to their employees.

There indeed will be many obstacles for states in addressing these healthcare issues in a comprehensive fashion, not the least of which will be ERISA, and the states likelihood of success if large self-insured companies are excluded from potential solutions.

In developing a sustainable program, states must also address some highly political issues as state mandates. Ideally, an objective (as much as one can be objective in the world of politics and special interests) analysis of each of the state mandates should occur to ensure there is an appropriate balance between cost, quality and access issues.

Funding, as one would expect, will be the major issue. The concept of "shared social responsibility" does indeed make sense, but the definition of "shared" will be tested to the limits.

The individual mandate concept, similar to the car insurance requirement, has merit especially since there is a portion of the uninsured that fall into the young, healthy and wealthy (or relatively wealthy) category. Any state initiative relating to universal coverage would also need to have subsidies for people who cannot afford insurance as a result of lower income or because they are a poor health risk.

As discussed previously, states will also need to conduct a thorough review of the individual insurance regulations, which, if not addressed appropriately, would be a major obstacle in the success of any universal insurance initiative.

The "pay or play" funding concept will be hotly debated. This debate may have a number of different spins to it. One of the key issues would be the potential applicability to ERISA employers (large self-insured employers). The exclusion of these employers would have a major financial impact on the sustainability of any universal access initiative.

There is also concern that “pay or play” could have a major negative impact on smaller companies as they try to survive in a very competitive marketplace.

Ultimately, universal health insurance coverage makes sense from a cost, quality and access to care perspective. Universal coverage would provide people with access to a more efficient quality oriented delivery system versus the stop-gap emergency room coverage that exists today. Ideally, universal coverage should be addressed at the national level, since states will have many obstacles in achieving a sustainable system. States may also need to evaluate interim steps that would more likely be financially sustainable, rather than developing an ill-conceived plan.

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